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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 2009-97

12 LAURA DEE MALAST
aka LAURIE TUCKER
13 aka LAURA GOLLY
THE OASIS APDO 10-5361
14 PUNTARENAS
COBANO, 5361
15 COSTA RICA

A C C U S A T I O N

16 Registered Nurse License No. 559518

17 Respondent.
18

19 Complainant alleges:

20 **PARTIES**

21 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation
22 solely in her official capacity as the Executive Officer of the Board of Registered Nursing,
23 Department of Consumer Affairs (Board).

24 2. On or about September 2, 1999, the Board of Registered Nursing issued
25 Registered Nurse License Number 559518 to Laura Dee Malast aka Laurie Tucker aka Laura
26 Golly (Respondent). The Registered Nurse License was in full force and effect at all times
27 relevant to the charges brought herein and will expire on December 31, 2008, unless renewed.

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1 “(b) Use any controlled substance as defined in Division 10 (commencing with
2 Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as
3 defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or
4 injurious to himself or herself, any other person, or the public or to the extent that such use
5 impairs his or her ability to conduct with safety to the public the practice authorized by his or her
6 license.”

7

8 “(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible
9 entries in any hospital, patient, or other record pertaining to the substances described in
10 subdivision (a) of this section.”

11 7. Section 2764 provides, in pertinent part, that the expiration of a license
12 shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the
13 licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the
14 Code, the Board may renew an expired license at any time within eight years after the expiration.

15 8. Health and Safety Code section 11173, subdivisions (a) and (b), state:

16 “(a) No person shall obtain or attempt to obtain controlled substances, or
17 procure or attempt to procure the administration of or prescription for controlled substances, (1)
18 by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

19 (b) No person shall make a false statement in any prescription, order, report,
20 or records, required by this division.”

21 **CONTROLLED SUBSTANCES/DANGEROUS DRUGS**

22 9. Demerol, a brand of meperidine hydrochloride, a derivative of the narcotic
23 substance pethidine, is a Schedule II controlled substance as designated by Health and Safety
24 Code section 11055(c)(1) and is categorized as a dangerous drug pursuant to Business and
25 Professions Code section 4022.

26 10. Dilaudid, a trade name for the narcotic substance hydromorphone, is
27 classified as a Schedule II controlled substance pursuant to Health and Safety Code section

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1 11055, subdivision (b)(1)(k), and is a dangerous drug within the meaning of Business and
2 Professions Code section 4022.

3 11. Marijuana is a hallucinogenic Schedule I controlled substance, as defined
4 in Health and Safety Code section 11054, subdivision (d)(13), and a dangerous drug according to
5 Business and Professions Code section 4022.

6 12. Morphine is a Schedule II controlled substance pursuant to Health and
7 Safety Code section 11055(b)(1)(M), and a dangerous drug pursuant to Business and Professions
8 Code section 4022.

9 COST RECOVERY

10 13. Section 125.3 provides, in pertinent part, that the Board may request the
11 administrative law judge to direct a licentiate found to have committed a violation or violations
12 of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
13 enforcement of the case.

14 SUMMARY OF FACTS

15 14. In or about December 2005, Respondent was employed by HRN Services
16 of West Covina, California (HRN). On or about December 21, 2005, the Board received a
17 complaint from the Regional Director of HRN, reporting that narcotic discrepancies had occurred
18 at two of Respondent's regular work places: (1) St. Mary Medical Center in Long Beach,
19 California (St. Mary Medical Center); and (2) Orange Coast Memorial Medical Center in
20 Fountain Valley, California (Orange Coast Memorial Medical Center).

21 15. St. Mary Medical Center. On or about December 21, 2005, the Board
22 received a complaint from the Charge Nurse at St. Mary Medical Center, reporting that
23 Respondent was removing Dilaudid from a medication dispensing system, using the access codes
24 of other staff members, as follows:

25 (1) Patient #2000161562. Although there were no physician orders for
26 Dilaudid, on or about July 24, 2005, at 1440 hours, Respondent withdrew two milligrams of
27 Dilaudid from the Pyxis medication dispensing system (Pyxis), using the access code of Jeff S.
28 There was no documentation of any administration of Dilaudid to this patient.

1 (2) Patient #2000161589. Although there was no physician order for
2 morphine, on or about July 24, 2005, at 0343 hours, Respondent withdrew 10 milligrams of
3 Morphine from Pyxis, using the access code of Tara A. There was no documentation of any
4 administration of Morphine to this patient.

5 (3) Patient #2000161609. Although there was no physician order for
6 Dilaudid, on or about July 24, 2005, at 1951 hours, Respondent withdrew 2 milligrams of
7 Dilaudid from Pyxis, using the access code of Bill Page. There was no documentation of any
8 administration of Dilaudid to this patient.

9 16. **Orange Coast Memorial Medical Center.** On or about December 8,
10 2005, an incident report was filed by the Director of Patient Care Services for HRN (the HRN
11 Director of Patient Care), indicating medication discrepancies involving Respondent and false or
12 incorrect documentation entries she made while on assignment at Orange Coast Memorial
13 Medical Center.

14 (1) Patient Stephanie A. On or about December 6, 2005, at 1801 hours,
15 Respondent withdrew 2 milligrams of Dilaudid without a doctor's order, and did not document
16 administering it to the patient, or wasting it, on any hospital record.

17 (2) Patient Phyllis B. On or about December 6, 2005, at 1245 hours,
18 Respondent removed 2 milligrams of Dilaudid without a doctor's order, and did not document
19 administering it, or wasting it, on any hospital record.

20 (3) Patient Shannon O. For December 2, 2005, physician orders for Patient
21 Shannon O. included two orders for 1 milligram of Dilaudid. However, on or about December 2,
22 2005, Respondent withdrew 3 milligrams of Dilaudid in three separate 1-milligram withdrawals:
23 1 milligram at 1209 hours, 1 milligram at 1336 hours, and 1 milligram at 1604 hours. In the
24 Medical Administration Record (MAR), Respondent documented giving .5 milligrams of
25 Dilaudid at 1116 hours, .5 milligrams at 1130 hours, and 1 milligram of Dilaudid at 1600 hours.
26 In the Nursing Notes, she documented giving .5 milligrams of Dilaudid at 1116 hours and 1130
27 hours, and 1 milligram of Dilaudid at 1205 hours and 1600 hours. The MAR documentation
28 does not match the Nursing Notes documentation. Although there were no physician orders for

1 Demerol for Patient Shannon O., on December 2, 2005, Respondent withdrew 75 milligrams of
2 Demerol at 1351 hours, and another 75 milligrams of Demerol at 1705 hours. In the MAR and in
3 the Nursing Notes, she documented giving 75 milligrams of Demerol at 1400 hours, but she did
4 not document any administration of Demerol to Shannon O. at or about 1705 hours, nor did she
5 document any wastage at or about 1705 hours.

6 (4) Patient Nancy S. On or about December 2, 2005, Respondent was caring
7 for Patient Nancy S. Physician orders were missing from this patient's file. Respondent
8 withdrew 2 milligrams of Dilaudid for Nancy S. at each of the following four times: 1231 hours,
9 1418 hours, 1438 hours, and 1639 hours. In the MAR, she documented administering
10 1 milligram of Dilaudid at each of the following times: 1240 hours, 1400 hours, and 1530 hours.
11 In the Nursing Notes, she documented administering 1 milligram of Dilaudid at each of the
12 following times: 1231 hours, 1418 hours, and 1438 hours. The MAR documentation details do
13 not match the Nursing Notes documentation. Additionally, there was no documentation of any
14 wastage at any time, nor was there any documentation of any administration or wastage of
15 Dilaudid at or about 1639 hours.

16 17. On or about December 6, 2005, in a drug screen ordered by her employer,
17 HRN, respondent tested positive for Marijuana and Morphine.

18 **FIRST CAUSE FOR DISCIPLINE**

19 **(Illegally Obtaining a Controlled Substance/Dangerous Drug)**

20 18. Respondent is subject to disciplinary action under Code section 2761,
21 subdivision (a), and Code section 2762, subdivision (a), for violating Health and Safety Code
22 section 11173, subdivision (a), in that Respondent obtained drugs illegally from two different
23 medical facilities while employed at HRN Services, Inc., West Covina, California, as a registry
24 nurse. Complainant now refers to and incorporates all the allegations contained in paragraphs 14
25 through 16, including all subparagraphs, as though set forth fully.

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PRAYER


WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 559518, issued to Respondent;

2. Ordering Respondent to pay the Board reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 10/24/08


RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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